

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2)

05321

For evidence see

CERTIFICATE OF DEATH

Reg. Dist. No. 290

FILM No. C 95 MAY 19 1945

1. PLACE OF DEATH:
County... Talbot
City or town... Easton Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hours 40 min.
Hospital, institution or street address where death occurred:
Removal Hospital
How long in hospital or institution? 3 hours 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Talbot
City or town... Potters Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Mrs. Mattie Bridges

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced
6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.)* Dec. 26
8. AGE: Years 72 Months Days If less than one day
* 72 hrs. min.

9. Birthplace James Quarter, Md.
(Town, county, and state)

10. Usual occupation H. W.

11. Industry or business

FATHER 12. Name Geo. W. LeGrand Scott
13. Birthplace James Quarter Md.

MOTHER 14. Maiden name Annie McFarman
15. Birthplace James Quarter Md.

16. Informant Guy Scott
Address Lutherville Md.

17. Burial Date thereof May 13, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Flint Cemetery
Location St. Michaels, Md.
Mourner & Mourner

18. Funeral director
Address St. Michaels, Md.

19. 5/15 1945 N.H. Nevins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1945 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1945, to May 10 1945, and that I last saw her alive on May 10 1945.

Immediate cause of death Exhaustion

Duo to Pericardial Aneurysm

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Antopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Palmer
M. D. or other
Address Easton Md Date signed 5-15-45

* Mrs. N.H. Nevius, registrar, states that the undertaker, Newnam & Harrison, gives the date of birth of the deceased as December 26, 1880 and the age of the deceased as 64 yrs. old.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. **294**

05322

1. PLACE OF DEATH:

County **Talbot**
City or town **Wittman**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **43 years**
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State **Md** County **Talbot**

City or town **Wittman Md.**
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

J. Oliver Bridges

3. (b) Social Security Number

None

4. Sex **male** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced **married**

6.(b) Name of husband or wife **Mattie V. Scott**

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) **April 15 1871**

8. AGE: Years **74** Months **0** Days **22** If less than one day _____ hrs. _____ min.

9. Birthplace **Bozman Talbot Co. Md.**
(Town, county, and state)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Joseph Bridges**

13. Birthplace **Bozman Md**

14. Maiden name **Malquet Anderson**

15. Birthplace **Baltimore Md.**

16. Informant **Norman O. Bridges**

Address **Wittman Md.**

17. **Burial** Date thereof **May 10 1945**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Olmit Cemetery**

Location **St. Michaels Rd**

Newnam & Harrison

16. Funeral director **St. Michaels, Md**

Address _____

19. **May 10 1945** 19 **45** **Anna Cary Thomas**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **MAY 7, 1945** 19 _____, at **4:45** P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Sept. 15, 1944** 19 _____, to **May 7, 1945** 19 _____

and that I last saw him alive on **April 21, 1945** 19 _____

Immediate cause of death **Coronary Disease**

DURATION

Due to **Chr. Rheumatoid Arthritis** **8 mos.**

Hypertension

Due to **Arteriosclerotic Nephritis**

Other conditions **Diabetes Mellitus**

(Include pregnancy within 3 months of death)

Major findings of operations **None**

Date of op. **None**

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ☒ Date of ☒

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) ☒

Means of injury ☒ Injured at work? ☒

23. SIGNATURE **J. B. Brewster**

M.D. or other **5.8.45**

Address **St. Michaels, Md.** Date signed _____

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 14 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46P

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH

County Albany
 City or town Denton Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 days
 Hospital, institution, or street address where death occurred:
Memorial Hospital, Easton, Md.
 How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline
 City or town Denton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____

3. (a) FULL NAME

Franklin Clifford Brown

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white married6. (b) Name of husband or wife Bessie E. Brown7. Birth date of deceased (mo., day, yr.) 1878 6. (c) If alive, give age 55 years8. AGE: Years 67 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Ohio
(Town, county, and state)10. Usual occupation builder

11. Industry or business

FATHER 12. Name James Brown13. Birthplace Del.MOTHER 14. Maiden name Margaret James15. Birthplace Ohio16. Informant Mrs. Bessie BrownAddress Denton Md.17. Burial Date thereof 5/1/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory DentonLocation Denton Md.18. Funeral director J. Virgil MooreAddress Denton Md.19. 5/9 19. 45 D.H. Neuner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 19. 45 at 12:52 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 19. 45 to May 9 19. 45and that I last saw him alive on May 9 19. 45Immediate cause of death Carcinoma of
esophagus

DURATION

6 months

Due to _____

Due to _____

Other conditions Valvular heartdisease
(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Kurt Lederer M.D. M. D. or otherAddress Sheer Anne Md. Date signed 5/11

RECEIVED
MAY 16 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

05324

CERTIFICATE OF DEATH

Reg. Dist. No. 290

For evidence see

FILM No. G 95 MAY 19 1945

1. PLACE OF DEATH:

County..... Talbot
City or town..... Easton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
State..... Maryland County..... Dorchester
City or town..... Rhodesdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

John Camper

3. (b) Social Security Number

4. Sex..... Male
5. Color or race..... Colored
6. (a) Single, married, widowed, or divorced.....
6. (b) Name of husband or wife..... Annie Y. Camper
6. (c) If alive, give age..... 54 years
7. Birth date of deceased (mo., day, yr.) * March 16.
8. AGE: Years..... 70 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Dorchester Co. Md.
(Town, county, and state)
10. Usual occupation..... Laborer
11. Industry or business..... Farm
12. Name..... Henry D. Camper
13. Birthplace..... Dorchester Co. Md.
14. Maiden name..... Catherine Fisher
15. Birthplace..... Dorchester Co. Md.

16. Informant..... Leroy Camper
Address..... Rhodesdale, Md. (R.D.)
17. Burial..... Date thereof..... May 11, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Thompsonstown
Location..... East New Market, Md.
18. Funeral director..... S. S. Thompson & Son
Address..... Federalsburg, Md.

19. 5/9 1945 H. H. Harris

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 8 1945 at 9:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 26 1945 to May 8 1945
and that I last saw him alive on May 8 1945

Immediate cause of death..... Obstruction, intestines
DURATION..... 3 wks

Due to..... Carcinoma Cecum 131
Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operation..... Carcinoma Cecum
Obstruction, intestines 5/7/45 Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE..... H. H. Harris
M. D. or other.....
Address..... Easton, Md.
Date signed..... 5/9/45

* Mrs. N.H. Nevius, Registrar, states that the undertaker, J.J. Frampton & Son gives the date of birth of the deceased as March 16, 1885 and the age of the deceased as 60 yrs. 1 mo. 22 days.

IMH



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution or street address where death occurred:

Memorial HospitalHow long on hospital or institution? 8 days

3. (a) FULL NAME

Lawrence L. Briggs

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mrs. Mary Ogden Briggs

7. Birth date of

deceased (mo., day, yr.)

Dec 1, 18766. (c) If alive, give age 68 years

8. AGE:

Years

68

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Saganaw, Michigan

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Heray Channing Briggs

13. Birthplace

N. Y.

MOTHER

14. Maiden name

Maria P. Bennett

15. Birthplace

N. Y.

16. Informant

Mary Ogden Briggs

Address

Offord Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 2, 1945

Cemetery or crematory

Admission

Location

Washington, D.C.

18. Funeral director

F. Ellis Clark

Address

Easton, Md.

19.

(Date rec'd by registrar)

19

45N. H. Neering

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 100

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 May 1945 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18 1945 to May 26 1945and that I last saw him alive on May 21 1945Immediate cause of death cerebral hemorrhage

DURATION

8 daysDue to Arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Schneider, M.D.

M. D. or other

Address Easton, Md. Date signed May 26, 1945

RECEIVED
JUN 4 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH
County... TALBOT, Md.
City or town... CARDOVA, Md.
If outside city or town limits, write RURAL and give nearest town
How long in above place of death? 67 years
Hospital, institution, or street address where death occurred:
Home.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Md. County... Talbot
City or town... Cardova
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

JONAS GREENHAWK

3. (b) Social Security Number

4. Sex MALE 5. Color or race White 6. (a) Single, married, widowed, or divorced MARRIED

8. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1881 6. (c) If alive, give age _____ years

8. AGE: Years 64 Months 6 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace TALBOT Co., Md.
(Town, county, and state)
LABOR.

10. Usual occupation _____

11. Industry or business _____

12. Name UNKNOWN
13. Birthplace _____

14. Maiden name UNKNOWN
15. Birthplace _____

16. Informant Mrs. FLORENCE GREENHAWK
Address CARDOVA, Md.

17. Burial Date thereof May 12/45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Spring Hill
Location Easton

18. Funeral director Carl W. Stafford
Address Easton, Md.

19. 5/11 19. 45 H. G. Neerues
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19. 45 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 43 to May 10 45 and that I last saw him alive on May 3 19. 45

Immediate cause of death Cerebral arteriosclerotic heart disease DURATION years

Due to _____

Due to _____

Other conditions Myocardial failure chronic
(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Kurt Lederer M.D. M. D. or other

Address Green Anne Hall Date signed 5/12

UNITED STATES DEPARTMENT OF HEALTH

1917

CHARTER OF DEATH

U.S. DEPARTMENT OF HEALTH

CHARTER OF DEATH

RECEIVED
MAY 17 1917
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH:

County... Talbot
 City or town... Oxford
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? rest of life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md. County... Talbot
 City or town... Oxford
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

William Oswald Laddaway

3. (b) Social Security Number

216-07-7025

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Clara Laddaway
 6. (c) If alive, give age 58 years
 7. Birth date of deceased (mo., day, yr.) May 9, 1872
 8. AGE: Years 73 Months 0 Days 14 If less than one day
 hrs. min.

9. Birthplace Oxford Md.
 (Town, county, and state)

10. Usual occupation Ship carpenter

11. Industry or business

12. Name William O. Laddaway

13. Birthplace Talbot Co. Md.

14. Maiden name Sophia Lisbon

15. Birthplace Talbot County, Md.

16. Informant Mr. J. M. O. Laddaway

Address Oxford, Md.

17. Burial (Burial, cremation, or removal) (Which?) Burial Date thereof May 26, 1945
 (month) (day) (year)

Cemetery or crematory Oxford Cemetery

Location Oxford Maryland

18. Funeral director Easton, Maryland

Address Easton, Maryland

19. May 26 19 45 Jon Labor Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 45 at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 19 45 to May 22 19 45
 and that I last saw him alive on May 22 19 45

Immediate cause of death Coronary thromboses

Due to Arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Jon Labor M. D. or other

Address Dorsey Md. Date signed 5/26/45

ATTACH TO TENTATIVE STATE QUALITY

CERTIFICATE OF BIRTH

RECEIVED
MAY 28 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4620

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... Talbot
 City or town... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5/8/45 - 5/12/45
 Hospital, institution, or street address where death occurred:
Memorial
 How long in hospital or institution? 5/3/45 - 5/12/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Queen Anne's
 City or town... Quantico
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... World War I ✓

3. (a) FULL NAME

William Kennedy Harrison Jr.

3. (b) Social Security Number

217-03-3666

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1887
 B. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
57 5 15 hrs. min.

9. Birthplace Hulmeville, Bucks Co. Pa.
 (Town, county, and state)

10. Usual occupation Contractor & Builder

11. Industry or business

12. Name William Kennedy Harrison

13. Birthplace Hulmeville Pa.

14. Maiden name Mary Ann Daniels

15. Birthplace Bridge Water Pa.

16. Informant Mrs. W. P. Sngle

Address 637, 9th Ave; Bethlehem. Pa.

17. Burial, cremation, or removal. Which? Burial Date thereof May 14, 1945
 (month) (day) (year)

Cemetery or crematory Beechwood

Location Hulmeville, Pa.

18. Funeral director Barton Bros

Address Greentree, Md.

19. 5/10 1945 N. H. Nevius
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1945 at 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1945, to May 12 1945
 and that I last saw him alive on May 12 1945

Immediate cause of death Carcinoma of colon DURATION 5 yrs.

Due to Colorectal Sclerosis, r. and a. Embolus

Due to Basal Resection for Carcinoma of Cecum

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma Cecum Date of op. 5/4/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. P. Sngle M. D. or other

Address Easton Md Date signed 5-15-45

RECEIVED

MAY 22 1945

BUREAU V.F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County..... Talbot
 City or town..... Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 4 years
 Hospital, institution, or street address where death occurred:
Cor. South & Park Sts.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Talbot
 City or town..... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cor. South & Park Sts.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Clinton W. Henry
 6.(c) If alive, give age..... 68 years
 7. Birth date of deceased (mo., day, yr.)..... March 12, 1877
 8. AGE: Years..... 68 Months..... 1 Days..... 28 If less than one day..... hrs. min.

9. Birthplace..... Talbot Co. Md.
(town, county, and state)10. Usual occupation..... Housewife11. Industry or business..... At Home12. Name..... Thomas E. Guverton13. Birthplace..... Md.14. Maiden name..... Martha Mullikin15. Birthplace..... Md.16. Informant..... J. Earl Henry (son)Address..... Easton, Md.17. Burial..... Burial Date thereof..... May 12, 1945
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory..... Spring HillLocation..... Easton, Md.18. Funeral director..... J. Otto BlackAddress..... Easton, Md.19. 5/11/45..... 45..... N. J. Davis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 10..... 1945 at 3. A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
two..... 1944 to May 10..... 1945
 and that I last saw her alive on about May 1..... 1945

Immediate cause of death..... Coronary occlusion DURATION.....Due to..... My hypertensionDue to..... Arterio SclerosisOther conditions..... Arterio Sclerosis General

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?.....

23. SIGNATURE..... N. J. Davis M. D. or otherAddress..... Easton, Md. Date signed 5/11/45

RECEIVED
MAY 16 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown 2411 N. Charles St., Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 290

FILM No. G 95 MAY 21 1945

1. PLACE OF DEATH:

County.....

City or town.....

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....

Street No.....

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... 5. Color of face..... 6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband..... 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days.....

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar..... Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I last saw him alive on.....

Immediate cause of death..... DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other.....

Address..... Date signed.....

RECEIVED
MAY 16 1945
BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 293

290

1. PLACE OF DEATH:
 County... TALBOT.
 City or town... CORDOVA, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long above place of death? 44
 Hospital, institution, or street address where death occurred:
HOME
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Talbot
 City or town... Cordova, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME
MAMIE KELLUM

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race C 6. (a) Single, married, or divorced MARRIED.

6. (b) Name of husband or wife HENRY KELLUM.

7. Birth date of deceased (mo., day, yr.) JULY. 4, 1900 6. (c) If alive, give age _____ years

8. AGE: Years 44 Months 10 Days 6 If less than one day _____ hrs. _____ min.

8. Birthplace CORDOVA, TALBOT, Md.
 (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business

12. Name JAMES WATKIN

13. Birthplace TALBOT Co. Md.

14. Maiden name AMELIA WRIGHT

15. Birthplace QUEEN ANNAS, Co. Md

18. Informant HENRY KELLUM.

Address CORDOVA, Md.

17. BURIAL Date thereof MAY 13, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory NEWTOWN CEMETERY.

Location CORDOVA TALBOT Co. Md

Funeral director Carl W. Stafford

Address Corton, Md.

19. 5/11 19 45 M. H. Neerue
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 45 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 19 45 to May 10 19 45

and that I last saw him alive on May 10 19 45

Immediate cause of death Endocarditis

10 per cent. of the heart

Due to _____

Due to _____

Other conditions Diabetes Mellitus 18 mos.

Pregnancy 9 9 mos.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Hayward J. Driskill M.D.

Corton, Md. M. D. or other

Address _____ Date signed 5/11/45

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

CERTIFICATE OF DEATH

LOCAL BOARD OF HEALTH

RECEIVED
MAY 17 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

Reg. Dist. No. 294

1. PLACE OF DEATH:

County Talbot
 City or town Wittman
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md County Talbot
 City or town Wittman
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. N. (If rural, give LOCATION)
 2. (a) If veteran, name war World War #1

3. (a) FULL NAME

Milton B. Kersey

3. (b) Social Security Number

220-16-9734

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Elsie V. Harrison
 7. Birth date of deceased (mo., day, yr.) Feb. 3 1888 5. (c) If alive, give age 44 years
 8. AGE: Years 57 Months 3 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Wittman Talbot Co. Md.
 (Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

12. Name Frank J. Kersey
 13. Birthplace McDaniel Md
 14. Maiden name Lina Baunber
 15. Birthplace Wittman Md.

16. Informant Mrs Elsie Kersey
 Address Wittman, Md

17. Burial Date thereof May 17, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Whisk Cemetery
 Location St. Michaels Md

18. Funeral director Newnam & Harrison
 Address St. Michaels Md.

19. May 16th 1945 Anna Carey Thomas
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1945 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1945 to May 14 1945
 and that I last saw him alive on _____ 19____

Immediate cause of death _____ DURATION _____

Accidental Drowning

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of May 14 1945

Where did injury occur? Wittman Talbot Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Crabbing near house

Means of injury drowning Injured at work? yes

23. SIGNATURE Anna Carey Thomas M. D. or other

Address Wittman Md Date signed May 15 1945

RECEIVED BY THE UNITED STATES MARSHAL

DEPARTMENT OF JUSTICE

RECEIVED
MAY 18 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1206)

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot EastonCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Easton Memorial Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KenCity or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Medford Harrington

3. (b) Social Security Number

214-12-63954. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Francis B. Lammie7. Birth date of deceased (mo., day, yr.) Nov 7 1908 8. AGE: Years 36 Months 6 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Centerville
(Town, county, and state)10. Usual occupation Truck driver11. Industry or business Dairy12. Name Clayton W. Lammie13. Birthplace Queen Ann Co. Md.14. Maiden name Boe Connolly15. Birthplace Queen Ann Co. Md.16. Informant Mr. Francis B. Lammie (Wife)Address Chestertown, Maryland17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 6/8/45
(month) (day) (year)Cemetery or crematory ChristieLocation Chestertown Maryland18. Funeral director Marvin U. WilliamsAddress Chestertown Maryland19. 5/30 19. 45 W.H. Neese
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-29-45 at 5:43 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 to May 29 1945and that I last saw him alive on May 29 1945Immediate cause of death Myocardial infarctionDue to Generalized peritonitisDue to acute intestinal obstruction due toOther conditions Post-operative adhesions, sigmoidNot due to cancer
(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. Edgar Baker M.D.Address Easton Date signed 6-4-45

RECEIVED
JUN 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12200

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:
 County... Talbot
 City or town... Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days 6 hrs. 35 min.
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Talbot
 City or town... West St. Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Ersk Louise Lipp

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife John E. Lipp

7. Birth date of deceased (mo., day, yr.) Nov. 1862 6. (c) If alive, give age..... years

8. AGE: Years 82 Months 6 Days..... If less than one day..... hrs. min.

9. Birthplace Salisbury, Maryland
 (Town, county, and state)

10. Usual occupation H. W.

11. Industry or business

FATHER 12. Name Joshua Coody

13. Birthplace Maryland

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant John E. Lipp

Address Easton, Maryland

17. (Burial, cremation, or removal, Which?) burial Date thereof May 16
 (month) (day) (year)

Cemetery or crematory Spring Hill

Location G. E. Clark Maus.

18. Funeral director Easton, Md.

Address Easton, Md.

19. 5/15 19 45 N. H. Neer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 45 at 9:48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1945 to May 12, 1945

and that I last saw him alive on May 12, 1945

Immediate cause of death.....

Delayed Shock

Due to pericarditis

Due to Myocardial Infarction

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations partial obstruction of aorta

Date of op. 5/17

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Palmer M. D. or other

Address Easton, Md. Date signed 5/15/45

RECEIVED
MAY 22 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown 2411 N. Charles St., Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH

705335

on FILM No. G 95 MAY 25 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County HarfordCity or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 9 days - Deep Creek on 4/26

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Anna Elizabeth SEWARD

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Charles H. Seward

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Mar 25 - 1869 18688. AGE: Years 76 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Worcester Co.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William R. Thomas13. Birthplace Worcester Co.14. Maiden name Anna Elizabeth Thomas15. Birthplace Worcester Co.16. Informant Mr. Milton SewardAddress Beltsville, Md.17. Burial Date thereof May 8 1945
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Old Trinity ChurchyardLocation Church Creek, Md.18. Funeral director Kenneth R. ThomasAddress Cambridge, Md.19. 577 19 45 H. H. Morris
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1945 19 45 at 10:10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 19 45 to May 6 19 45and that I last saw him alive on May 6 19 45

Immediate cause of death

Acute Myocardial infarction

DURATION

3 daysDue to Chronic Myocarditis6 wksDue to Malignant Hypertension1 yr.Other conditions Chronic fibrosis of the heart7

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

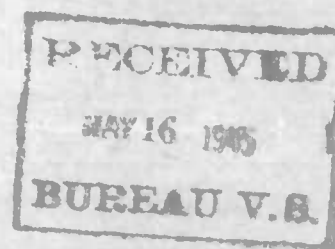
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. Glen Baker M.D.

M. D. or other

Address Beltsville Date signed 5-10-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 53 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Martha E. Seymour

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Joseph T. Seymour

7. Birth date of

deceased (mo., day, yr.)

Mar. 4 18768. (c) If alive, give age 69 years

8. AGE:

Years

69

Months

1

Days

6

If less than one day

hrs.

min.

9. Birthplace

Cambridge Md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

James L. Andrews

12. Name

Bethlehem Md.

13. Birthplace

Martha Wooters

14. Maiden name

Lewistown Md

15. Birthplace

Joseph T. Seymour

16. Informant

St. Michaels. Md.

Address

Burial

17. (Burial, cremation, or removal, which?)

Date thereof

May 14 1945

Cemetery or crematory

St. Michaels. Md

Location

Newman & Harrison

18. Funeral director

St. Michaels. Md.

Address

19. May 14 1945

(Date rec'd by registrar)

19. 4519. 45John H. Hovewakes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County TalbotCity or town St. Michaels. Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 11 1945 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1, 1944 to May 11 1945and that I last saw him alive on May 10, 1945

Immediate cause of death

Acute Chemic

DURATION

Over 12 wks

Due to

Chronic Interstitial Nephritis

Due to

By pertussis

Other conditions

Generalized Interstitial

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of ✓

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

P. B. Hovewakes

Address

St. Michaels Md

M. D. or other

Date signed 5-11-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED
JUN 11 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs.
 Hospital, institution, or street address where death occurred:
410 North St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town 410 North St.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Easton, Md.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7609

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 19 45 at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED
MAY 17 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 442

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County SubsCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County SubsCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. 110 Subs St Easton
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

James Floyd Stuart

3. (b) Social Security Number

720-01-93274. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced M.6. (b) Name of husband or wife Virginia Lee Stuart6. (c) If alive, give age 75 years7. Birth date of deceased (mo., day, yr.) January 27, 1913.8. AGE: Years 34 Months 3 Days 7 If less than one day
.....hrs.min.9. Birthplace Easton, Subs, Ind.
(Town, county, and state)10. Usual occupation Barber

11. Industry or business

12. Name William A. Stuart13. Birthplace Ind.14. Maiden name Martha Ellen Seymour15. Birthplace Ind.16. Informant Charles StuartAddress Easton, Ind.17. Burial Date thereof May 7, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Spring HillLocation Easton, Ind.18. Funeral director Robert ClarkAddress Easton, Ind.19. 5/7 19. 45 N. H. Neer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1945 19. 2:30 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 1, 1945 19. to May 4, 1945and that I last saw him alive on MAY 4, 1945 19.

Immediate cause of death

HODGKINS DISEASE
(LYMPHADENOMA)

DURATION

2 yrsDue to UNKNOWN

Due to

Other conditions Diabetes MELLITUS

(Include pregnancy within 8 months of death)

Major findings of operations NONEDate of op. ✓Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ✓ Date of ✓Where did injury occur? ✓
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) ✓Means of injury ✓ Injured at work? ✓23. SIGNATURE Philip B. Lewis M.D.Address St. Michaels, Md Date signed 5-4-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County SubotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bates Lilghman

3. (b) Social Security Number

4. Sex

M.

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Ida Pine Lilghman

7. Birth date of

deceased (mo., day, yr.)

1891

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

54

.....hrs.min.

9. Birthplace

Subot County
(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

FATHER
MOTHER

12. Name

Tom Lilghman

13. Birthplace

MD

14. Maiden name

Matella Pines

15. Birthplace

MD

16. Informant

R. T. Lilghman

Address

Easton R. 2 Box 107A. Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 30, 1945
(month) (day) (year)

Cemetery or crematory

New Chapel

Location

Easton, Md

18. Funeral director

W. H. Clark

Address

Easton, Md

19.

5/29 45
(Date rec'd by registrar)

19.

45

W. H. Neer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Subot

City or town

Easton, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 27

19

45 at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h

alive on

19

Immediate cause of death

Coronary occlusion

DURATION

Normal

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Louis P. Harty, M.D., J. H. Harty
Easton, Md

M. D. or other

Address

Date signed 5-29-45

RECEIVED
JUN 2 1945
BUREAU V.E.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BFC*

CERTIFICATE OF DEATH

Reg. Dist. No. *290*

1. PLACE OF DEATH:
County *Talbot*
City or town *Easton, Md. (Rural)*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *Maryland* County *Talbot*
City or town *Easton*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *Rural*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Katie Wilson

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *Colored* 6. (a) Single, married, widowed, or divorced *Widowed*
6. (b) Name of husband or wife *Louis R. Wilson*
7. Birth date of deceased (mo., day, yr.) *April 16, 1870*
8. AGE: Years *75* Months *1* Days *3* If less than one day
.....hrs.min.

9. Birthplace *Maryland*
(Town, county, and state)

10. Usual occupation *Housework*

11. Industry or business

FATHER 12. Name *Charles E. Roberts*
13. Birthplace *Md.*
MOTHER 14. Maiden name *Elizabeth Roberts*
15. Birthplace *Md.*

16. Informant *Louis R. Wilson*
Address *7555 Madison Ave. Baltimore, Md.*

17. *Burial* Date thereof *May 22, 1945*
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory *Unionville Cemetery*
Location *Easton, Md. (Rural)*

18. Funeral director *J. E. Clark*
Address *Easton, Md.*

19. *5/22* 19 *45* *N. H. Neenan*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 19* 19 *45* at *2:30* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 13* 19 *45* to *May 19* 19 *45*
and that I last saw h. *is* alive on *May 17, 1945* 19 *45*

Immediate cause of death *Arteriosclerotic Nephritis* DURATION *Several yrs.*

Due to *Arteriosclerotic Nephritis*

Due to *Hypertension*

Other conditions *Generalized Arteriosclerosis*

(Include pregnancy within 8 months of death)

Major findings of operations *None*

Date of op. *None*

Autopsy results *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ☒

Accident, suicide, or homicide. ☒ Date of *May 19, 1945*

Where did injury occur? *At home* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ☒

Means of injury *Stroke* Injured at work? ☒

23. SIGNATURE *P. Brewer* M. D. or other

Address *St. Michaels U.S.* Date signed *5/22/45*

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JUN 2 1945
BUREAU V.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2411)

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: *Pallat*
 County.....
 City or town *Easton md*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *Life*
 Hospital, institution, or street address where death occurred: *na*
 How long in hospital or institution? *na*

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *md* County *Pallat*
 City or town *Easton md*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *130*
 (If rural, give LOCATION)
 2.(a) If veteran, name war *World war no 1*

3. (a) FULL NAME *Charles L. Walford*
 4. Sex *male* 5. Color or race *col* 6.(a) Single, married, widowed, or divorced *Single*
 6.(b) Name of husband or wife *na*
 7. Birth date of deceased (mo., day, yr.) *1893* 6.(c) If alive, give age *na* years

3. (b) Social Security Number
220-09-1319

MEDICAL CERTIFICATION

2D. DATE OF DEATH *May 6th* 19*45* at *8-25-45* M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 6* 19*45* to *May 6* 19*45*
 and that I last saw him alive on *May 6* 19*45*

Immediate cause of death *Intussusception* DURATION *7 days*

Due to *Constipation*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *Harold J. Miller M.D.* M. D. or other

Address *Easton md* Date signed *5/5/45*

8. AGE: Years Months Days If less than one day
53 hrs. min.
 9. Birthplace *Easton md*
 (Town, county, and state)
 1D. Usual occupation *Labourer*
 11. Industry or business *Same as above*
 12. Name *Louis Walford*
 13. Birthplace *Easton md*
 14. Maiden name *Annie Nichols*
 15. Birthplace *Easton md*
 16. Informant *Sarah Walford Davis*
 Address *Easton md*
 17. *Burial* Date thereof *May 10 - 1945*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory *Richardson*
 Location *Easton md*
 18. Funeral director *James H. Stewart*
 Address *Baltimore md*
 19. *5/7* 19 *45* *N.H. Nevins*
 (Date rec'd by registrar) Registrar

RECEIVED
MAY 16 1945
BUREAU V.S.